Long Term Care Highlights

North Dakota Department of Health
Division of Health Facilities

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Special points of interest:

- Residents must be provided services to meet their individual needs.
- Learn more about the new fast track review process for Medicare beneficiaries.
- Dispensers withalcohol-based hand rub solutions can be installed in facilities.
- Smoke detectors are required in resident rooms and public areas.

Rehabilitation Service Options

By Ken Gieser, P.T.
Health Facilities Surveyor

Long term care (LTC) residents often are admitted to the facilities in a deconditioned state. The LTC facility will recognize this deconditioned state and may address the deconditioning in a number of ways, including diet, medication and a program of physical activity (i.e., exercise, ambulation). A recent research study (1) concluded that higher levels of therapy intensity were related to improved length of stay efficiency and increased the likelihood of patients' being discharged to the community.

State and federal regulations provide guidance and limitations regarding the use of direct therapy services, restorative nursing and maintenance services. A number of LTC regulations make reference to requirements of the LTC facility to meet the needs of its residents. These include, but are not limited to, federal regulations F309, F310, F311, F312, F317, F318, F406 and F407.

Treatment programs provided by a licensed therapist and billed as "therapy" are limited, in part, by Medicare Part A and Part B regulations and by the respective profession's state practice act. Treatment programs provided that are not considered "therapy" may be considered as "restorative" or "maintenance" programs. Potential reimbursement for "therapy" and "restorative" programs is addressed by the respective Resource Utilization Group (RUG) category (2).

The Resident Assessment Instrument (RAI) (3) manual defines restorative care as "… nursing interventions that assist or promote the resident's ability to attain his or her maximum functional potential …" and must meet the following criteria: "Measurable objectives and interventions

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Rehabilitation Service Options (cont)

must be documented in the care plan and in the clinical record. Evidence of periodic evaluation by licensed nurse must be present in the clinical record. Nurse assistants/aides must be trained in the techniques that promote resident involvement in the activity. These activities are carried out or supervised by members of the nursing staff. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents. This category does not include exercise groups with more than four residents per supervising helper or care giver."

"Maintenance" programs are those programs and services provided by facility staff that does not meet the criteria for "therapy" or "restorative."

The LTC facility staff must determine what level of service is required based on the individual resident assessment. However, basing the assessment on what services the facility is willing to provide may not meet the requirements of F309 "… the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being …" or F278 "… The assessment must accurately reflect the resident's status …" A "one-size fits-all" approach does not meet the needs of each individual resident; i.e. all residents receive only maintenance or only restorative or only therapy services. For example:

1. A resident is admitted to the LTC facility from an acute care facility with recommendations for a therapy service (PT, OT or speech). The facility does not offer that service. The assessment that the resident does not require the service CANNOT be based on the lack of availability of that service or the lack of a payer source.

2. A resident is admitted to the LTC facility with recommendations for a maintenance program. The facility's policy is to place all similar residents on a restorative therapy program a minimum of fifteen minutes per day, six days per week, for reimbursement purposes. The assessment that the resident requires a higher level of care CANNOT be based on reimbursement issues or on a philosophy of every resident receives the same level of care.

The type and extent of the physical activity program provided to residents must be based on an accurate assessment by a qualified person. The results of that assessment must be care planned so that all staff are aware of the plan. The care plan must be carried out by qualified trained staff and periodically reviewed and updated as determined by the needs of the resident. The services provided must be accurately documented for medical, legal and reimbursement purposes.

The provision of physical activity programs (exercise, ambulation) is a complex issue. Ideally, every resident in every facility would receive direct therapy services from a licensed therapy professional. This is neither practical nor necessary. Is a restorative therapy program as defined by the RAI Manual, provided by a staff member trained in programs specific to each resident's needs, appropriate? Is a maintenance therapy program as defined by the RAI Manual, provided by a facility staff member with limited training, appropriate? Is a combination of direct therapy services, restorative services, or maintenance services of greatest benefit to the resident?

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Rehabilitation Service Options (cont)

Residents must be provided the services needed to meet their individual needs within the regulations and requirements previously identified. Facility staffs must accurately assess each resident and determine what services are required to meet the needs of the individual resident.

References:
Jette DU, Warren RL, Wirtalla C. Rehabilitation in skilled nursing facilities: effect of nursing staff and therapy intensity on outcomes. Am J Phys Med Rehabil. 2004; Sep:704-12.

Centers for Medicare & Medicaid Services. Long-Term Care Resident Assessment Instrument User's Manual, Version 2.0., 2002, Dec: Chapter 6.

New Fast-Track Review Process for Beneficiaries in Original Medicare (Rev. 6-21-05)

Beginning July 1, 2005, beneficiaries in Original Medicare will have access to a new fast-track expedited review process when Medicare coverage of their home health, skilled nursing, comprehensive outpatient rehabilitation or hospice services is about to end. Home health agencies, skilled nursing facilities, CORFs and hospices ("providers") will be required to notify individuals of this new right when they anticipate that Medicare coverage of their services will end. On April 29, 2005, the two notices associated with the implementation of these expedited reviews were published for comment in the Federal Register — the Notice of Medicare Provider Non-Coverage (Generic Notice) and the Detailed Explanation of Non-Coverage (Detailed Notice). The Office of Management and Budget approved these notices for use through 2008. Copies of the notices, as well as the instructions for using them, can be found on CMS' Beneficiary Notices Initiative webpage located at www.cms.hhs.gov/medicare/bni.

New Fast-Track (cont.)

Approval of the new standardized notices and implementation of the expedited review process, we want to emphasize that – between July 1, 2005 and Oct. 1, 2005 – affected providers and suppliers may use either the standardized notices or the model notices that have been available on the CMS website since April. As of Oct. 1, 2005, providers must use the new standardized notices exclusively. CMS will continue to provide additional updates on the BNI page and through CMS provider and Open Door Forum Listservs as additional information becomes available.

What About the Current Advance Beneficiary Notices (ABNs)?

As noted above, providers have historically used ABNs to inform beneficiaries of impending service terminations. For the most part, the need for ABNs in these situations is eliminated by the new expedited review procedures. However, the ABNs still will serve a valuable role under other circumstances, and we recognize that the existing ABNs and the accompanying instructions will need minor modifications in light of the new expedited review process.

Thus, on May 6, 2005, CMS published for comment in the Federal Register a revised Home Health Advance Beneficiary Notice (HHABN). (See www.cms.hhs.gov/regulations/pra for more information). The comment period for the revised HHABN closed June 6, 2005. CMS is currently reviewing the public comments and will issue the new HHABN and implementing instructions when we have completed that review. Until that process is complete, HHAs should continue using the current HHABN as they have in the past.

Similarly, CMS is continuing its efforts to implement a new, simplified Skilled Nursing Facility Advance Beneficiary Notice (SNFABN). As with the HHABN, CMS is evaluating the SNFABN and the accompanying instructions in light of the new expedited review process, as well as reviewing public comments CMS has already received on these notices. Until the new SNFABN is made final, SNF providers may continue to use either the SNFABN or one of the five SNF denial letters in situations where the expedited review notice is not appropriate. For more information about the expedited review process, please contact the Quality Improvement Organization (QIO) at 701.852.4231 or www.ndhcri.org.

Alcohol-Based Hand Rub Solutions

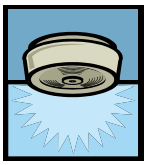
By Monte Engel, P.E., Manager, Building Standards and Life Safety Code

The Centers for Medicare & Medicaid Services (CMS) took action that will allow nursing facilities, hospitals, ambulatory surgical centers and other health-care facilities to install dispensers of alcohol-based hand rub sanitizers in exit corridors under specified conditions. This had not been allowed previously because of concerns that the alcohol rubs may serve as an accelerant in the event of a fire and block access to exits. Studies have shown that if certain conditions are met, the fire hazard is greatly reduced, while there can be a significant benefit in reducing acquired infections.

Effective May 24, 2005, alcohol-based hand sanitizers may be installed in nursing facilities, including exit corridors, if the following criteria are met:

- The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls.
- The dispensers are installed in a manner that adequately protects against access by vulnerable populations, such as residents in dementia units.
- Where dispensers are installed in a corridor, the corridor must be at least 6 feet wide.
- The maximum individual dispenser fluid capacity is limited to 0.3 gallons (1.2 liters) for dispensers in rooms, corridors and areas open to corridors.
- The maximum individual dispenser fluid capacity is limited to 0.5 gallons (2.0 liters) for dispensers in suites of rooms.
- The dispensers must be installed at least 4 feet apart.
- Not more than a total of 10 gallons (37.8 liters) of solution can be in use in a single smoke compartment outside a storage cabinet.
- Storage of more than 5 gallons (18.9 liters) of solution in a single smoke compartment must meet the requirements of NFPA 30, *Flammable and Combustible Liquids Code*.
- The dispensers cannot be installed over or directly adjacent to an ignition source.
- Dispensers installed directly over carpeted floor surfaces are permitted only in smoke compartments protected by automatic sprinkler systems.

CMS has agreed that alcohol-based hand sanitizer dispensers, when installed properly in exit corridors, do not decrease fire safety. Any fire safety concerns about the use of the hand sanitizers are more than offset by the potential for health-care facilities to improve their infection control practices. The availability of the dispensers will likely decrease the number of health-care acquired infections, thus improving public health and safety in health-care facilities.



Smoke Detectors in Resident Rooms

By Monte Engel, P.E., Manager, Building Standards and Life Safety Code

The Centers for Medicare & Medicaid Services (CMS) recently announced a requirement for smoke detectors to be installed in resident rooms and public areas. CMS took this action in response to two tragic fires in nursing facilities in Connecticut and Tennessee in 2003. Neither nursing facility had smoke detectors in the resident rooms where the fires originated. A review of the two incidents asserted that smoke detectors could have resulted in quicker staff response that may have led to a better outcome.

Nursing facilities will be required to install battery-operated smoke detectors in resident sleeping rooms and public areas by May 24, 2006. Facilities will further be required to have a program for testing, maintenance and battery replacement to ensure the reliability of the smoke detectors.

Nursing facilities that have a hard-wired AC smoke detection system in resident rooms and public areas that is installed, tested and maintained in accordance with NFPA 72, *National Fire Alarm Code,* are exempt from this requirement. Also, facilities that have an automatic sprinkler system throughout that is installed, tested and maintained in accordance with NFPA 13, *Standard for the Installation of Sprinkler Systems* and NFPA 25, *Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems,* are exempt.

Facilities that choose to install a hard-wired smoke detector system in resident rooms and public areas will be exempt from the requirement to install battery-operated smoke detectors in these locations. A hard-wired smoke detector system is a system that is wired to both electrical and fire alarm systems. The detectors draw their energy from a facility's electrical system and use batteries as back-ups in case of power failure. In addition, detectors communicate with one another so that an alarm in one room would trigger an alarm in every room. The detectors also communicate with the facility's fire alarm system, thus notifying the fire department of the situation.

If a facility chooses to install a hard-wired system in resident rooms and public areas, it would not have to install battery-operated smoke detectors because such a system will exceed the requirements. Facilities that have installed sprinkler systems throughout also will be exempt from the proposed requirement to install smoke detectors, because such a system will exceed the requirement.

Revised Guidance to Surveyors—Tags F315 and F316

The Centers for Medicare & Medicaid Services (CMS) has issued revised guidance to surveyors for Section 483.25(d)-Urinary Incontinence. Tags F315 and F316.

Summary of Changes: Current Guidance to Surveyors is entirely replaced effective June 28, 2005. The two tags are being combined as one, which will become F315. Tag F316 will be deleted from the list of tagged regulations. The regulatory text for both tags will be combined, followed by the revised guidance to surveyors. The regulation for Urinary Incontinence has not changed, but the language will be combined into one tag.

The guidance to surveyors is very lengthy (37 pages) and it has not been placed on the CMS website yet, but should be up on the web soon. Please check the following website:

www.cms.hhs.gov/manuals/107_som/som107ap_pp_guidelines_ltcf.pdf

Certified Nurse Aide Facts of the Day

When completing the CNA testing application for Promissor through the North Dakota Board of Nursing, please have the applicant fill in the name of the nursing facility and city where he/she completed the training program, if applicable, or the facility affiliated with the training program. This is important information that is placed on the CNA registry.

RAI Update

By Patricia Rotenberger, R.N.
State MDS Coordinator

The final revisions for the June 2005 update to the RAI User's Manual can be found at the following website: www.cms.hhs.gov/quality/mds20/default.asp?

These revisions correct errors and clarify sections of the MDS. For coding purposes, sections K and M have the most revisions. In section M, the word sore/s was changed to ulcer/s; the definitions and the examples were clarified.

Section W. Supplemental Items will become effective Oct. 1, 2005. This section is still in draft form, but can be viewed at this website: www.cms.hhs.gov/quality/mds20/SectionW.asp. If you have any questions about this information, please call Pat Rotenberger at 328.2364.

The Fall RAI Basic Training conference is scheduled for Oct. 12 & 13, 2005 in Bismarck, N.D.

Take Time To

Work it is the price of success
Play it is the secret to perpetual youth
Think it is the source of power
Read it is the fountain of wisdom
Pray it is conversation with God
Laugh it is the music of the soul
Listen it is the pathway to understanding
Dream it is hitching your wagon to a star
Worship it is the highway of reverence
Love and Be Loved it is the gift of God

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